Minutes of the 28th Annual General Meeting of Discovery Health Medical Scheme ("DHMS"/"the Scheme") held on 08 June 2023 at 09:00 at 1 Discovery Place, Sandton

1 Welcome and Quorum

The Chairperson of the Board of Trustees ("Board"), John Butler SC, welcomed all present to the 28th Annual General Meeting ("AGM") of Discovery Health Medical Scheme ("DHMS"/"the Scheme"). The Chairperson welcomed the delegate from the Council for Medical Schemes ("CMS"/"Regulator"), Ms Thandiwe Baloyi-Motaung.

The Chairperson briefed the members present at the AGM on the proceedings for the day and commented that:

- The meeting is being streamed live on the Scheme's website and the recording will be made available on the Scheme's website.
- The Trustees, the Scheme Office, and the Administrator will be available after the meeting to respond to other questions from Principal Members ("Members"), which could not be asked during the meeting.
- Questions relating to the business of the AGM and/or presentations made will be allowed at the designated time.
- Interpreters have been made available to translate, should a Member want to ask a question in a language other than English.

The Chairperson confirmed that to ensure that the AGM and all the related processes are conducted in terms of the Scheme Rules and allow Members to participate, the Scheme appointed Mazars as an independent third-party service provider to oversee the AGM and AGM-related processes, including the proxy appointment processes and the voting to be conducted at the AGM. He called upon Mr Ishan Bhowani from Mazars, to confirm that the minimum number of 15 Members is present and confirm that the AGM is quorate.

Mr Bhowani addressed the meeting and indicated that, in terms of the Scheme Rule 25.1.4, at least 15 Members should be present in person at the meeting to declare the meeting quorate. He informed attendees that should a quorum not be constituted within 30 minutes of the AGM commencing, then the meeting must be postponed to a date as set by the Board. Mr Bhowani performed a roll call on a sample of Members. Members were instructed to raise their hands upon hearing their name, to indicate their presence for noting. He called out the names of Members of the Scheme who registered to attend the meeting. Mr Bhowani confirmed that there were at least 15 Members present in person at the meeting and that the AGM was therefore declared quorate.

The Chairperson proceeded to confirm the meeting quorate and declared the meeting open.

- The Chairperson handed over to Mr Bhowani to explain the voting and voting registration processes. Mr Bhowani that Members in good standing would be allowed to participate and vote at the AGM. Mazars electoral officers would be available to direct Members in this regard. Members would be guided to the voter registration area.
- After registration, members would receive a voting access card and the electoral officers would direct them to the voting room to cast their votes. Mr Bhowani emphasised the fact that voting would be electronic using iPads.

Mr Bhowani proceeded to declare the voting open and noted that it will remain open until 16:00 that afternoon (viz. 08 June 2023).

Mr Bhowani handed back to the Chairperson.

Confirmation of the Agenda

The Chairperson presented the agenda of the meeting as communicated to members.

The Chairperson called upon Members to approve and second the approval of the agenda. Mr Ronald Silbermann proposed the approval of the agenda, and Mr Clive Peter Ucko seconded the proposal. The agenda was duly confirmed.

2 Confirmation of the Minutes of the 2022 Annual General Meeting

The Chairperson referred Members to the copy of the minutes of the 2022 AGM, as included in the meeting pack given to Members at the meeting, and which were published Scheme's webpage.

Mr Howard Snoyman proposed the approval of the minutes, and Ms Henda van Deventer seconded the proposal. The minutes were thus duly approved.

3 Tabling of the 2022 Integrated Report, including the Scheme's Annual Financial Statements for the financial year ended 31 December 2022

The Chairperson referred to the financial statements for the year ending 31 December 2022 and advised that these were laid before the meeting in terms of Rule 25.1.5 of the Scheme Rules
The Chairperson commented that presentations would be made before any questions would be taken. A presentation would be made by the Principal Officer of DHMS, Ms Charlotte Mbewu, followed by a presentation by the CEO of DH, Dr Ryan Noach.

3.1 Presentation by Principal Officer of DHMS, Ms Charlotte Mbewu

Ms Mbewu commenced by providing an overview of the topics that she would be covering in her presentation including the financial results and the financial performance of the Scheme for the financial year ended 31 December 2022.

The presentation highlighted the following aspects:

Current Landscape for Members and the Scheme

- Ms Mbewu acknowledged the work performed, led by the Board, in protecting all the Members from a healthcare and financial perspective.
- The current operating environment of the Scheme was highlighted. South Africa and the world have been operating in a turbulent period with increased macro-economic uncertainty. Secondly, there are secondary effects of the COVID-19 pandemic, particularly reduced health-seeking behaviour as a result of fear around the risk of being inside healthcare facilities. Thirdly, in the latter part of 2022, as the world has emerged from a pandemic state, there has been an increase in utilisation of healthcare introducing new pressures from an industry pricing perspective.
- 2022 saw increased macro-economic uncertainty including global geopolitical tensions, energy crisis in South Africa and high inflationary cycle which has added upward pressure on interest rates
- When assessing the environment from a COVID-19 perspective, there has been a transition from the pandemic phase to the endemic state and recorded decreased rates of infection. Even though there is an endemic state, one of the key concerns is that the Scheme's data indicates a reduction in screening and prevention services. resulting in the diagnosis of chronic disease at later stages of progression than seen before the pandemic.
- The following statistics were shared as examples of the reduction in screening and preventative benefit utilisation:
  - A 50% reduction in health checks
  - A 15% reduction in mammogram checks
  - A 10% reduction in prostate screening
- The importance of highlighting the reduction in screening is because people are unaware of their health risks and therefore are unable to partner with their primary healthcare practitioners or specialists in the case where specialist care is required. For example, in cancer diagnosis, there has been an 11% reduction in early-stage identification. Early identification and diagnosis provide Members who become patients, and their oncologists and those assisting oncologists, with an opportunity to begin the patient's treatment which increases the chance of better outcomes. When treatment is started at a later stage of progression, the treatment becomes more complex. From a Scheme perspective, when treatment is started at a later stage, the cost associated with that treatment increases. Similar statistics have been observed in diabetes diagnosis as well.
- Another concern facing the Scheme, South Africa, and the world, is the burden of mental health and the prevalence thereof. Currently, close to a billion people (970 million people as displayed on the screen) have a mental health

condition. The prevailing conditions listed are depression and anxiety. Both conditions have increased the most (among mental health conditions) between the periods 2020 to 2021.

- Utilisation has started increasing and is reverting to pre-pandemic levels. This reflects an increased need for healthcare and introduces renewed pressure on industry pricing as indicated by the contribution increase of schemes reflecting increased utilisation rates. From 2022 there is a return to normal levels of utilisation, and it is observed that the levels are now back to following the trajectory that was set pre-COVID-19. It is important for the Scheme to monitor the trajectory and utilisation levels to optimise the Scheme's pricing for the utilisation levels observed.
- Ms Mbewu emphasised the importance of the Scheme Members' understanding of the various considerations taken when setting the Scheme's pricing or contribution rate for the following year.
- In determining the Scheme pricing, a balance of the following factors is established:
  - Ensuring the Scheme remains sustainable in both the short and long term
  - Ensuring benefits for Members are enhanced with contributions keeping up with those benefits, and in the event, Members require treatment, that the benefits are helpful.
  - Ensuring, whilst considering external factors on healthcare, that the Scheme pricing remains affordable for Members in real terms and remains affordable when compared to the Scheme's competitors.
- Through the years of the COVID-19 pandemic, managing contribution levels has necessitated a different approach to strategy, particularly as schemes were faced with holding excess reserves due to the decline in utilisation. The industry has overall used different strategies to manage those excess reserves. Some schemes used the excess reserves to lower contribution increases. Schemes like DHMS used the strategy of deferring contribution increases which ensured that the Scheme's claims experience keeps up with the contribution levels. The strategy is preferred because once a scheme under-prices, a compounding effect of the under-pricing is observed, and the under-pricing is always carried into. future years resulting in members experiencing a price shock at some time in the future. The following factors were presented:
  - The Scheme ensures comprehensive cover within the various benefit options that it offers.
  - The Scheme's strategy is continuously aimed at achieving marked quantitative and qualitative improved patient outcomes and healthcare experience of Members.
  - Ensuring sustainability and affordability of the Scheme, which affects Members and the Scheme's ability to continue operating into the foreseeable future.

Protecting and caring for Members

- Ms Mbewu shared the cost of the ten (10) highest Member claims that the Scheme funded in 2022, which amounted to R46.8 million. A table of data was displayed on the screen detailing the following information:
  - The highest claim amounting to R6.4 million was funded and constituted over 10% of the ten highest Member claims that the Scheme funded.
  - The age range of Members ranged from newborns (aged 0 years) to pensioners (aged 63 years)
  - The table is indicative of the importance of monitoring one's medical needs throughout one's life and those of their beneficiaries. It is important to also note that the highest claim in FY2022 costing R6.4 million would take 284 years' worth of contributions for one person to cover on their own. This speaks to the power of pooling resources within a medical scheme to ensure that the scheme is funded appropriately and being able to leverage from cross-subsidisation.
- Continuing the topic of claims, DHMS is ahead of the industry as detailed in figures published in the CMS Industry Report for 2021. The following figures were shared:
  - The industry has a payout ratio of 90% and DHMS has a payout ratio of 96.7%
  - The above figures are of key consideration because it means DHMS, as a Scheme, avoids and mitigates the risk of Members having co-payments or out-of-pocket payments.
- The Scheme has taken great lengths with its Administrator, DH, to set up various hospital and service provider networks. This is done to allow Members to seek care from a provider who has a negotiated contract and tariff with the Scheme to optimise the contributions of the Scheme and excess reserves to the benefit of its Members.
- In terms of optimising healthcare for Members, the Scheme follows the path of value-based care which is vital in the industry. Value-based healthcare is one of the key mechanisms in ensuring the Scheme pays providers for value and in paying for value, treating providers are reimbursed based on the quality of patient outcomes and better healthcare experiences, as opposed to just rewarding treating providers for transactions. The following are examples of programmes implementing value-based care:

- Centres of Excellence resulted in a successful Same-day Discharge Arthroplasty (SDDA) pilot programme in 2022 with 72% of patients discharged on the same day, 96% experiencing complication-free recovery, and a 3-week average of the period patients returned to work.
- Value-based care in chronic disease management: The result of Members registering for the diabetes programme has produced a marked improvement in the annual testing rate from a haemoglobin A1c (HbA1c) perspective and shown that these Members require less hospital admission as a result of the support provided through the programme.
- Oncology and the challenges it creates: The Scheme must ensure the provision of programmes and extensive cover, and ensure Members receive appropriate care at the time of diagnosis. This benefit was implemented in 2010 and the following are the results:
  - R22 billion has been paid out in lieu of the benefit from the Scheme
  - enhancement of cover for the Oncology Innovation Benefit in 2022

- Speaking to mental wellness, Ms Mbewu shared that there was a 19% increase in the prevalence of Members claiming for mental health services between 2018 and 2022. DHMS offers a programme for mental health to Members which provides funding for a basket of care, funded from the risk benefit and not their medical savings. It allows for three additional visits to a Premier Plus GP, medication, and either individual or group psychotherapy sessions.

Ensuring the sustainability of the Scheme

- The Annual Financial Statements were included in the meeting packs and covered by Ms Mbewu during her presentation, which highlighted the following on the financial position of DHMS at 31 December 2022:
  - A deficit in net healthcare result (contributions less claims less expenses) which was anticipated due to contribution income received by the Scheme being lower than usual due to the deferral strategy
  - AAA credit rating from the Credit Rating organisation
  - 35.11% Solvency ratio
  - R28.9 billion in reserves
- Key metrics for the Scheme's sustainability measured by the Scheme include:
  - Number of beneficiaries, which increased to 2 810 992 in 2022. The population is generally healthy, and this subsidises the older population and is key for the Scheme's sustainability.
  - Membership growth.
  - Plan movements – 97.2% of the membership base maintained the previous plans meaning the Scheme has appropriately priced plans and benefit designs are appropriate.
  - Contribution increases.
- Growth of DHMS relative to the rest of the market as per quarter 1 to 3 of 2022 results published by the Regulator:
  - 1.14% increase in beneficiaries, surpassing the rest of the market
  - Market share increased by 20 basis points from 57.6% in 2021 to 57.8% at the end of the third quarter in 2022.
- Most of the funds that are received from Members go to funding claims. In 2022, 91.7% of contributions funded claims. DHMS also monitors and measures administration expenditure to ensure that administration expenditure benefits Members. A decline in administration expenses as a percentage of gross contribution income continues. DHMS is ranked fifth lowest out of eighteen open medical schemes and this speaks to financial prudence, proper governance and management, and oversight applied over the administration expenditure of the Scheme. In terms of administration expenditure together with managed care costs of the Scheme, the value that has been received on or derived by the Scheme from DH is continuously assessed.
- In 2021, for every R1 which has been spent on managed care and administration expenses, the Scheme has received value of R2.02. This means the value that is derived by DHMS on behalf of its Members, supersedes the Rand cost which is paid to DH to deliver these services on behalf of the Scheme.

Regulatory and governance excellence

- Highlighting the value of the strong and independent governance structure within the Scheme, Ms Mbewu acknowledged the Board which has a majority of elected members and is an integral part in terms of the Scheme Rules, Board Charter and in terms of the Medical Schemes Act. In executing its fiduciary responsibilities, the Board is responsible for strategic oversight of the Scheme.

- The National Health Insurance ("NHI") Act:
  - The bill was recommended and passed by the Parliamentary Committee on Health. Baring a few changes, the version passed is the same as the draft version shared with medical schemes, the private sector and other stakeholders for their commentary and extensive oral and written submissions. Unfortunately, the version of the passed bill being very similar to the previous one, implies that those submissions were ignored by the legislators.
  - As a medical scheme, DHMS supports the need for universal healthcare cover because universal healthcare cover will afford all South Africans with quality healthcare.
  - DHMS believes that a single-funder model is not ideal to deliver universal healthcare cover and believes that there is a role for public and private collaboration to resolve the various healthcare challenges of the country, and ensure equitable access to quality healthcare cover for all.
- Low-cost Benefit Option ("LCBO") framework and environment:
  - This mechanism affords the government the ability to deliver aspects of NHI.
  - The Scheme continues its engagements around LCBOs. One of the key aspects is how the Scheme can deliver LCBOs in a way that provides access to private healthcare for the uninsured. This can be addressed through relaxation around the regulatory requirements of prescribed minimum benefits.
- PCR (polymerase chain reaction) test pricing complaint:
  - DHMS is engaging with an industry body representative, the Health Funders Association ("HFA"), over the PCR test pricing complaint, which has received some media attention.
  - DHMS strongly advocates for pricing that does not result in any excessive profits being made by any one player in the healthcare market.
  - Unfortunately, the information and various other aspects that have been considered through the engagement with HFA have led DHMS to believe that there was some undue profiting in the space of PCR by some pathology laboratories. DHMS is of the view that the complaint levied with the Competition Commission is to try address the issue of undue profiting and ensure that excessive profiting can be refunded to the schemes for the benefit of members.

Looking into 2023 and beyond

- The WELLTH Fund:
  - Members would have received communication explaining the nature of the WELLTH Fund as a wellness benefit introduced in 2023. The fund enables Members to receive up to R10,000 in benefits for a family depending on the size of the family.
  - Already 304,000 DHMS Members have participated and since January 2023, the Scheme has already funded R201 million in claims related to screening and preventative benefits purely out of the WELLTH Fund benefit.
  - It is a very extensive benefit covering a broad range of discretionary healthcare services.
- Extensive work has been done by the Scheme in partnership with DH to continue to develop various care programmes and one of those implemented at the beginning of 2023 is the Cardiometabolic Syndrome programme. These programmes are designed to identify long-term illnesses at an earlier stage. Predictive models are used to identify Members who are at risk of developing any of these preventable illnesses and a plan is put together for them using data analytics. Through the support of a co-ordinated programme, one can ensure that they will be aware of their health risks, and that the objective of the programme is to mitigate the progression of the illness.
- These are 12-month programmes and have a basket of care from glucose testing and nutritional assessments to general practitioner ("GP") assessments and a few other aspects as well, to try and assist Members to stay healthy.
- All these various programmes that the Scheme has designed and implemented speak to the effort that goes in from a population health management aspect and share the targeted approach to population health management. They also highlight the Scheme's efforts in mitigating the high prevalence of chronic conditions which can be preventative.
- In conclusion, there is extensive work both inside and outside of the office to ensure that DHMS continues to protect Members. The emergence of the utilisation of data analytics supported by Artificial Intelligence has been an interesting venture by the Scheme and provided insight into various areas of the business. It has also assisted in ensuring that healthcare programmes are specific and targeted whilst at the same time optimising the use of option benefits ensuring that Members are receiving care, have access to certain drugs, etc.

3.2 Presentation by the CEO of Discovery Health (Pty) Limited, Dr Ryan Noach

Dr Noach started his presentation by providing an overview of the topics that he would be covering. The presentation highlighted the following aspects:

Review of industry performance

- Dr Noach shared that at an industry level, healthcare interest has grown since the pandemic period. The amount of Google searches by people seeking to understand healthcare cover increased by 40% from pre-COVID. A survey was completed by DHMS Members asking their sentiments regarding the importance of health, wellness, and particularly mental health. More than 10% of those Members felt that healthcare is much more important today relative to the pre-COVID-19 periods.
- Two charts were referenced. The lapse rate is down and remains down relative to the pre-COVID-19 period. In June 2023, the lapse rate ended on an upwards path, approaching the pre-COVID-19 levels. New business flows have been excellent through 2020 and 2021 as demonstrated by Ms Mbewu. Thus, the high demand has translated into growth for DHMS.
- Over the years in the medical scheme industry, there has been a consolidation of the number of medical schemes, reducing from 49 open schemes to 16 over 20 years, effectively a 67% reduction in open schemes.
- The chart on the right-hand side of the slide displayed shows that the larger medical schemes are attracting a far greater proportion of scheme growth which is particularly evident through the case of DHMS and the next three biggest schemes.
- The financial stability offered by large medical schemes and by DHMS through volatile claims periods is better than that of smaller medical schemes.
- Dr Noach emphasised that despite so much pressure on disposable income, DHMS has not observed an increase in plan downgrades. He proceeded to discuss the movements in plans and the reasons for the movement for the 2022/23 year-end:
    - 97% of Members remained on their current plan – this is consistent with prior years.
    - 1.6% of Members upgraded their plan – an analysis of that grouping being patients recently diagnosed with a severe health care challenge. The upgrade is to seek greater benefits, which is rational and intuitive.
    - 1.3% of Members downgraded their plan – an analysis of that grouping indicates the majority of downgrades are a result of affordability challenges arising from several circumstances, i.e., younger people leaving a parent's policy and electing to join the medical scheme in their individual capacities.
- In the central panel of the display, the average age of joiners and the ratio of chronic illness of those Members joining the Scheme is better than the existing Members of the Scheme and the growth in the rest of the market. As a result, the Scheme's ageing is slowed down which is very favourable for Members. For every year that population ages, their healthcare costs in basic health economic principles increase by about 3%. This means a year of ageing is accompanied by about a 3% increase in healthcare cost/demand/utilisation. Last year DHMS only aged by 0.3 of the year which is good as that slows the utilisation impact on claims costs which ultimately reflects in lower contribution increases.
- Visible through Scheme analytics is that integration of the DH membership with a Vitality (a separate entity within the Discovery group) policy is very favourable for DHMS. 40% of DHMS Members have a Vitality policy – within this group, more favourable actuarial dynamics arise:
    - A doubled generation of net operating surplus
    - 32% improved retention or persistence of DHMS Members with a Vitality policy
    - These Members with Vitality policies are healthier and tend to be less of a financial cost to the Scheme; and
    - These Members with Vitality policies remain with DHMS longer, thus, in actuarial terms, Vitality can be recognised as a central feature of the Scheme's long-term sustainability.
- Growing plans are very favourable for DHMS; unfortunately, the same is not true for three of the largest schemes following DHMS and competitors of DHMS. The surplus per beneficiary per annum in DHMS amounts to R1,568.00 for this period which is a positive surplus being produced by the Scheme. The next six largest open medical schemes competing with DHMS are losing money per beneficiary per annum for the same period.
- Dr Noach took the attendees through an analysis of which plans are growing. Referencing a matrix which was displayed, he compared the plans in DHMS and their positioning and growth, to those of the next six largest open schemes:

- DHMS plans positioned right of the zero axis are all in the surplus generating area. This means these plans are growing and producing a surplus. DHMS plans positioned on the bottom left are shrinking plans and are making losses. The Scheme's growth trajectory is thus very favourable for the Members.

- Schemes showing operating losses unfortunately have to make decisions to either trade-off benefits or have big price increases.
- A range of schemes have introduced unusual benefit cuts through the 2022/23 year-end period, such as but not limited to hospital networks being introduced on non-network plans and variable increases.
- This signals that the industry is trying to catch up with the pricing that emerged during COVID-19 through the approaches, relative to DHMS's strategy of deferred contribution increases. Most recently, in May 2023, a large competitor of DHMS introduced an interim increase over and above the January 2023 increase which is potentially disruptive to a person's financial planning.
- Contrasting DHMS's position to the rest of the market:
  - R8.6 billion was returned to Members from excess reserves through delayed contribution increases. DHMS continues to invest in benefits that are good for Members such as increases in the oncology thresholds, the disease prevention programme, and the WELLTH Fund. All these efforts have left Members in a very well-protected position.

Regulatory update

Dr Noach shared the following regulatory topics and updates:

- NHI
  - Two weeks ago, the Parliamentary Portfolio Committee for Health ("the Committee") approved an amended version of the NHI bill.
  - As indicated by Ms Mbewu, it is dismaying to the Scheme, the industry, private and public sector, NGOs, civil society, and specialists and health economists, that the input from these multi-stakeholders was disregarded. After all the multi-stakeholder input and after a four-year consultation process, an amended version of the bill was approved even though it was almost identical to the first draft of the bill.
  - The Parliamentary Portfolio Committee for Health obtained a legal opinion from the parliamentary law advisor which raises a series of constitutional legal concerns around the Act. The legal opinion was annexed to the report and amended Act and passed to the National Assembly awaiting the next stage of the approval processes.
  - DH and DHMS support an NHI scheme and health policy reform, however, as proposed and presented to the Committee, DH proposed a blended funding model with multi-funding which would be more sustainable and fiscally secure for the country. This model would represent the collaboration of the private and public sectors, using the best of both, and with simultaneous regulatory reform in both environments to ultimately provide a sustainable health policy for the country. The current proposed model poses a severe economic threat to the country.
  - Dr Noach shared the next steps in the process of passing the NHI Act:
    - The Bill will be taken to the National Assembly where it will be approved.
    - Then, it will be taken to the National Council of Provinces. This is likely to be a challenging process due to the clause in the draft Act.
    - Next, if passed by the National Council of Provinces, the drafted Act will go back to the National Assembly for final ratification.
    - Lastly, the Act is taken to the President for signature and promulgation.
  - DH's response to the published NHI bill in 2019 included:
    - Providing detailed submissions to the National Department of Health and Parliamentary Portfolio Committee supporting NHI and proposing the multi-funded model for faster expansion and lower fiscal risk.
    - Presenting at Parliamentary Portfolio Committee.
    - Supporting Business Unity South Africa's ("BUSA's") dedicated Health Policy Sub-committee to lead business engagements with government, hopefully ultimately with the Presidency, and certainly also with the Department of Health through BUSA.
    - Collaborating with HFA to make industry-wide constructive submissions and engagements.

- Communicating widely with all stakeholders, especially healthcare professionals to maintain calm and thoughtful engagements to mitigate the immediate risk posed by the NHI draft around healthcare professionals, where sentiment has been negatively affected by this process.

- LCBO Framework
  - This initiative has been debated in the medical scheme industry since 2007. The LCBO framework is seemingly close to being approved by CMS and recommended to the Minister of Health.
  - The framework from CMS recommends that LCBOs be brought into medical schemes like DHMS. This would be a wonderful development for the country as it is a progressive way of financing healthcare and a step towards making healthcare more accessible and affordable to South Africans.
  - There are about 5 to 8 million South Africans who are currently formally employed and would love to gain access to private healthcare if they had the means to finance it through practical medical scheme options.
  - Currently, entry into a medical scheme cover costs approximately R1 000 per month in normal commercial circumstances. In terms of the LCBO, these entry products would cost approximately R300 to R400 per month and would offer only out-of-hospital cover and primary healthcare cover, taking away the burden of the public sector having to offer primary healthcare to all those members.
  - Those members would also be eligible for the medical scheme tax credit according to today's law. Together with an employer subsidy, it would mean these products are largely free to these lower-income employees. It is critically important that CMS holds steadfast, notwithstanding the release of the NHI bill, and puts forward the proposal to the Minister and the Department of Health to allow DHMS to introduce these LCBOs. The Scheme is ready and has applied to CMS, for the last two year-ends, to approve an LCBO in DHMS's benefits. DHMS has also designed and priced this plan and has built supporting networks and servicing environments to manage the plan.

- Update on the litigation underway with the Road Accident Fund ("RAF")
  - Background to the litigation between DHMS and the RAF and the flow of money between the two entities:
    - When a DHMS Member gets into a vehicle accident, the Scheme indemnifies the Member for their healthcare claims immediately according to their plan benefits.
    - The Scheme will cover the costs of any treatment that the Member may need following a vehicle accident. The Scheme then asks for the consent of the Member to brief an attorney, which DH does on behalf of DHMS, to recover those costs from the RAF.
    - RAF is supported by fuel taxes and exists to support the costs of medical care and disability following any road accident. Unfortunately, the RAF unilaterally and without warning declared that it would stop processing medical scheme members' claims. The basis of this decision is not understood. There is an understanding that the RAF is currently under financial pressure and experiencing various governance issues. However, to single out medical scheme members who pay the same taxes, which have the same constitutional rights as anybody else in the country and declare that their claims are not eligible to be paid by RAF due to the members' scheme having already paid them does not make any sense.
    - The Scheme recovered about R82 million in 2022 from the RAF, in lieu of the cost of claims paid for members' medical injuries. Should RAF pursue this strategy of excluding medical scheme members' claims, the Scheme can lose the recovered cost of claims.
  - RAF litigation progress to date:
    - DH took RAF to court and has won three particular court hearings:
      - One at the High Court by way of urgency and awarded in DH's favour.
      - Secondly, an interdict was given to instruct the RAF to immediately start processing medical scheme members' claims.
      - Lastly, DH defended the leave to appeal at the High Court and at the Supreme Court afterwards, in which both times the Courts refused the appeals petitioned by RAF
    - Most recently, the RAF, unfortunately, chose to appeal to the Constitutional Court despite scathing judgements against them on all three written judgements.
  - DH is working very hard to try and protect the Scheme's and Members' interests through this litigation. The matter between DH and RAF poses no risk to the payment of Members' claims for vehicle accidents whatsoever, as the Scheme indemnifies Members against those. The only effect of RAF's strategy is the

reduction of the Scheme's recoveries from the RAF, which ultimately would put pressure on Member contributions.

- Update on the Section 59 Enquiry
  - In 2020, an Enquiry was commissioned as a result of a complaint against the Government Employees Medical Scheme initially, and subsequently broadened to include other medical schemes for racial discrimination against healthcare professionals. The interim report was published in January 2019 and pursuant to that, the industry, including DH and DHMS, submitted extensive analyses that refuted the findings of the interim report.
  - The interim report accused the industry at large of this racial discrimination on the basis that more black doctors were found to be guilty of fraudulent infringements than were white doctors.
  - Proper statistical analysis and measurement of the proportions showed absolutely no disproportionality or bias in any of the forensic investigations. DH contracted the prior Statistician-General of South Africa, Dr Pali Lehohla, who did the work on behalf of DH and DHMS. Dr Lehohla made an independent submission to the Section 59 Panel demonstrating absolute fairness and the lack of any bias or racial discrimination in the forensic and fraudulent investigations.
  - Members of the Scheme should expect the final report from the Section 59 Panel. DH and DHMS hope and trust in the law, that all independent submissions are taken into account and that the report is appropriately amended to reflect the facts as contained in these submissions.

Healthcare trends in 2023 and beyond

- Distinctive trends influencing South African healthcare in 2023, namely:

  Major restructure of the healthcare system
  - Two examples of restructuring:
    - Optum – Traditionally focused only on healthcare has now introduced plan benefits in some of their insurance options to buy food for their members. Realising that the social determinants of health, as demonstrated by COVID-19, have a direct relevance on people's long-term healthcare. Optum has now acquired a payment system integrated with supermarket chains to fund the purchase of food for their members in certain circumstances.
    - Amazon – probably the world's biggest consumer technology company has now made large acquisitions in the healthcare space. It has acquired a pharmacy business and built a massive pharmacy ordering and distribution business called Amazon Pharmacy. Secondly, it has acquired a primary healthcare business with primary healthcare facilities, bricks-and-mortar, a huge electronic health records system with plenty of health data and a virtual consultation platform, now called Amazon Clinic. Lastly, Amazon offers free teleconsultation to its Amazon Prime subscribers wherein one can talk to a doctor and get their medicine scripted and delivered to their door from Amazon's distribution centres.
  - Restructuring is also seen in the South African market with pharmacy retailers offering primary healthcare insurance or running healthcare clinics. Even DH, as an insurance administrator, is doing things that are not traditional, such as providing care to patients in the form of hospital at home and point-of-care pathology testing.

  A framework from Advisory.com demonstrates shifts in places of care, Increasing lifestyle diseases resulting from rising chronic disease, ageing of populations and long-term impact of COVID-19
  - Chronic ratios continue to increase: The ratio of Members inside DHMS with chronic disease is now approximated at 30% and has increased steadily since 2019.
  - There is an increase in complex cases as well:
    - An adage in health economics is that 80% of the Members in a risk pool would be healthy and 20% would tend to be sick. The 20% who need healthcare funding would be funded by the 80% of healthy Members.
    - That has shifted over time to a 60/40 ratio. This has a material impact on the economic and financial strategies of schemes. It is still heavily geared on the top-end and there is still a small number of Members with complex healthcare challenges. This small number of sick Members represents a very high proportion of cost in the Scheme and the majority of the risk in DHMS is for 16% of the Members. Thus, it is important to tailor programmes, optimising the quality of care and health outcomes.

Mental illness continues to escalate rapidly

- Global prevalence of depression and anxiety: The World Health Organization ("WHO") estimates a 25% increase in the prevalence of anxiety and depression in this post-COVID-19 period.
- Prevalence of mental health conditions in DHMS Members is primarily driven by depression:
  - In DHMS there has been an increase of approximately 19% from 2018 to 2020 in mental illness.
- Global spending on mental health and wellness mobile apps:
  - DH and DHMS are exploring various means to support people with mental illness.
  - Exciting areas and opportunities are rising from the digitisation of the treatment of mental illness.
  - DH and DHMS have worked on a strategy and Members should look out for the launch (later this year), where exciting announcements around mental health and digital support for mental health will be made.

Care backlogs and utilisation recovers to 2019 levels

- COVID-19 infections have dropped from the peak in 2021, while cardiovascular remains the largest chapter.
  - Long-COVID is a challenge that DH and DHMS face. In the 12 months following an acute infection, there is a higher propensity towards developing diabetes and cardiovascular disease.
- Surgical utilisation returning to 2019 base levels and medical admissions in 2023 are above 2019 base levels:
  - With utilisation levels back to normal, scheme pricing is critical, and the Scheme must ensure contributions and claims match.
  - As described by Ms Mbewu, not all medical schemes in South Africa anticipated utilisation recovery and thus their matching of contributions and claims has fallen behind and left them distressed.
- Prevention and screening volumes are increasing; however, they remain lower than pre-COVID-19 levels:
  - Large reductions in prevention and screening are observed right across the board of tests – mammograms, pap smears, health checks, and HIV screening events. Whilst Vitality members have more screening and prevention conducted than non-Vitality members, levels in both groups have dramatically declined.
- In 2023 DHMS introduced the WELLTH Fund to boost Member screening and access to preventive healthcare services:
  - The Scheme's response to the decline in screening and preventative healthcare services is a rational, unique and differentiated response of using the excess solvency that developed during COVID-19 and the excess capital which the Scheme does not require, and returning it to Members through the WELLTH Fund – giving up to R10 000 per policy depending on the size of the policy and the number of beneficiaries for a range of health services.

Accelerated scaling of value-based care payment arrangements

- DH is accelerating the scaling of value-based care arrangements to guarantee quality.
- A displayed chart showed DH's proportion of value-based care contracts. It is pleasing that 53% of the money spent by DHMS on hospitalisation is now covered by these risk-sharing contracts.
- The relevance of these contracts to Members is that through risk-sharing contracts, there is an aligned incentive between hospital groups and DHMS to deliver a high-quality experience for patients and Members, as well as get them out of the hospital quickly and efficiently without re-admission.
- These aligned contracts are very much Member-centric and in the interest of better care.

Advances in Large Language Models

- DH has been studying large language models and the insight is fascinating.
- The data displayed compared ChatGPT, Instagram and Spotify showing their paths to achieving one million users on the respective platforms:
  - Spotify gained one million users in 150 days
  - Instagram gained one million users in 75 days
  - ChatGPT gained one million users in 5 days
- Having this data shows how these platforms and models are sweeping society and how disruptive this technology is. There is relevance for the application of this technology to healthcare in many ways. DH is investing heavily in the development tools using large language models to ultimately make it easier for Members to search and ask questions about Scheme benefits, and for DH consultants to better support Members.

Rise of the empowered healthcare consumer

- Rise of the empowered healthcare consumer is driving demand for transparency to influence decision-making and choices.
- With the modernisation of healthcare, patients now want to understand their health and be part of decision-making. Healthcare consumers are now much more empowered.
- It is not a punitive process of measuring and punishing; to the contrary, the processing of measuring and comparing drives improvement. Data from Sweden demonstrates significant healthcare system improvement just from transparency and visibility.
- DH has introduced a tool for Members recently to model improvement through transparency and visibility. Members are now able, to compare hospital performance in conducted procedures. A Member can search for their procedure, prior to hospital admission, and compare how the hospital they are choosing to go to performs relative to other hospitals in the procedure they have scheduled. Due to this type of reporting being heavily dependent on sufficient data per hospital, not every hospital is included especially if the hospital's dataset is not big enough. Insufficient datasets will not provide statistically relevant results and cannot be relied on.

Maximising DHMS Member Value

- The six areas that DH has invested into, financially and from a human capital aspect, aimed to develop capabilities that maximise DHMS Member value are:

Digital Innovation

- DH has invested over R600 million over the last few years to create a digital platform that seeks to place Members at the centre of a digital healthcare ecosystem and convert Scheme benefits, Scheme servicing and support to the healthcare professionals on a platform which is called HealthID on the one side and the Members through Connected Care on the other side.
- These platforms extend access to care through functions like virtual consultations on the platform.
- Quality of care is improved through the dashboards used by doctors and patients, enabling both parties to view their compliance with disease management programmes and check the progress of the patient.
- The platform further enhances experiences by sharing the patient's clinical data, with their explicit consent, with their healthcare professionals so they may engage the patient.
- Various interaction functionality is available on the platform, like:
  - Direct interaction through instant messaging channels like WhatsApp
  - Direct interaction through live chatting with DHMS consultants.

  These exist should one want to talk to a consultant about their benefits.

Healthcare system transformation and supporting shifts in healthcare

- DH supports DHMS claims to ensure that utilisation is properly managed, and the costs are under control. This is called strategic risk management and has been developed over the years as a sophisticated set of risk management assets. A pyramid representing the evolution of these assets over the years was displayed and showed there are several foundational tools which DH built, many years ago, to understand the services and enhanced features that healthcare providers are providing; to build alternate reimbursement methodologies for value-based contracts; to understand clinical measures and governance; to do health technology assessments; and build formularies for medicines.
- These efforts have now progressed to a focus on quality and care co-ordination.
- Currently, it is the era of next-generation care delivery. DH is now investing in assets to deliver care to Members that will seek to improve quality and reduce costs. DH's focus of interventions is where this does not seem to be taking place, and so where DH can be disruptive.
- Further examples of these investments include:
  - Development of the Discovery Health Hospital at Home Programme with the capacity for 750 home-based ward admissions at any point in time. Evidence-based work that is being done by Harvard Medical School, and Brigham and Women's Hospital operating in the USA demonstrates an improvement in quality of care:

        - Alternative home-based care is safe, and the outcomes thereof are the same or sometimes of better quality than from hospital-based care.
        - Alternative home-based care is approximately 20% or more cheaper than traditional hospital admissions which means it is more sustainable for the Scheme.
        - Perception ratings from patients show a preference for this type of admission as there is proximity to next-of-kin, the comfort of one's home, and other specific advantages for those that have a suitable home environment.
    - The miniature laboratory system that DH has invested in delivers point-of-care pathology. Almost laptop size devices can perform a blood test and within 10 to 15 minutes give patients and their healthcare professionals the results. The devices are also able to upload results onto cloud storage, so they remain in the Member's electronic health record. Together with partners Mediclinic and Dis-chem Pharmacies, DH is rolling out these miniature laboratories across South Africa with the potential enormous savings of 20% to 30% for DHMS.
    - Lastly, telemedicine consults are becoming very useful and ubiquitously used by Members. DH is making constant improvements to the platform. Doctors are now undertaking specific training on these tools and will know when to ask a patient to come in and see them in person if required.

Population health management

- A central part of population health management and disease management is understanding data. DH has large teams of actuaries, data scientists, and highly structured data to enable DH and DHMS to use the data to the advantage of Members and proactively identify people who need health risk management.
- Once identified, DHMS can reach out and enrol Members into the relevant programme. The diabetes management programme as an example shows 3% more patients remained stable or improved their disease stage for those that are enrolled and a 10% reduction in hospital costs (fewer patients hospitalised for their care, with more patients being managed out-of-hospital).

Clinical risk intelligence

- As shown earlier, the segmentation of Scheme membership shows that 16% of Members account for a very high proportion of Scheme cost, approximating 50% of the Scheme's cost. By running algorithms of predictive models, DH can classify Members and stratify their risk. This enables bespoke care co-ordination and management programmes to be designed to improve their care.
- Member care programmes which look after Members with complex conditions or Members at very high risk for hospital admissions help to improve the quality of their out-of-hospital care and enables Members to avoid the inconvenience and risk of hospital admissions.
- Through these predictive algorithms, DH and DHMS can proactively offer access to the Advanced Illness Benefit for Members in the palliative phase of care and life, allowing them to die in dignity and at the same time generating improved efficiencies and savings for DHMS.

Quality measurement

- Dr Noach described the value-based programmes done by the Scheme and DH – starting with the Coronary Artery Disease Care Programme:
    - Years ago, DHMS noticed that the number of angiograms conducted in the examinations done in patients with chest pain in South Africa was disproportionately high relative to other markets. About 60% of those angiograms proved to be normal.
    - Unfortunately, this is very costly and exposes patients to complications. Working with the South African Society of Cardiologists, the Scheme was able to co-design a programme in a collaborative way that continues to pay cardiologists for an episode of care for someone who has chest pain; however, it no longer pays the cardiologist to do an angiogram.
    - Previously, if cardiologists used angiograms, they got paid more. DHMS now removes the remuneration incentive entirely. This has resulted in more appropriate use of coronary angiograms rather than unnecessary invasive tests. Cardiologists have been very supportive; the Scheme has experienced savings and has protected Members from unnecessary angiograms.
- Other programmes include the Oncology and Palliative Care Programmes.

Proactive servicing

- Operationally, the Scheme takes enormous pride in the quality of service that is delivered to its members. The scale of the service is immense, with about 40,000 telephone calls from Members a day. Other digital channels cater for about 100,000 stakeholder engagements.
- DHMS works to improve every service area with brilliant people and systems for optimal support.
- Benchmarking that support, DH is up there with the leading benchmarks in the world. The engagement channels through which Members choose to engage with the Scheme become largely digital with 72% of all engagements with DH on behalf of DHMS in 2022 being via digital channels.
- The processes for building these digital journeys are mapped out through the hospitalisation journey and out-of-hospital claim journey (displayed on the presentation).
- The DH data science teams have developed a list of indices that help the Scheme understand, predict, and best manage Member service requirements. Predictive models are used to capture the sentiment behind queries and predict reasons a Member is calling before we converse with them. Indices are now deployed in production systems and the following are a few examples:
  - A contactability model helps DH reach a Member more easily, giving the best time of day and the best number to call the Member on. It supports DH service agents as well.
  - A production model called Service Storms was championed by the DH Chief Operating Officer, Karen Sanderson. Service storms happen when Members land up calling multiple times to resolve the same issue.
  - When a Member requires a service, data about the Member is used to match the Member to somebody they think the Member will like, because likeability improves the service experience. When comparing a group that is affinity-matched and a group that was not affinity-matched, the perception rates are materially higher in the group that was affinity matched.
  - Intelligent dashboards for service consultants help them provide service to Members through the implementation of a new client relationship management system called Omnichannel.
  - Artificial intelligence ("AI") is now used to personalise servicing experiences. The Ask Discovery service available on the website is an AI virtual agent dealing with queries for generalised information and is used to support service consultants to ensure that Members are provided with appropriate personalised and correct answers.
- Truecaller has been incorporated into operations so that outbound calls made to Members show DH's identity and the reasons DH is calling. As a result, contactability has improved by 15%.
- Some benchmarks of DH's services against the best in the world and local competitors:
  - The outcomes of the 2022 global benchmarking show that DH performs well for first call resolution, customer sentiment measurement, and the net promoter score measure.
  - More importantly, this year in the 2023 results of the three landmark surveys conducted, DH came first for employer rating, health professional provider rating and financial advisor rating relative to the local competitors in the market. These three landmark surveys that are done annually are done on employers, healthcare professionals, and financial advisors asking them who the leading service providers are and ranking them in a very detailed scoring system.

The Chairperson proceeded to open the floor for questions on the 2022 financial statements and the presentations provided.

1. Dr Murendeni Liphadzi commented that the top three benefit options of the Scheme were in a deficit and enquired whether there are plans in place to recover the deficit position of the options. Dr Liphadzi raised a further question on KeyCare and whether the Scheme anticipates Members contributing the R300 towards the NHI bill, considering the demographic using the plan. He further raised a suggestion that transformational issues should be addressed in the financial statements at subsequent AGMs considering that the Scheme is regulated by the CMS as well as the Minister's office. It would benefit the Members to see the demographics as they relate to risk contribution income, healthcare expenditure and gross healthcare results. The transformation approach should, in addition, be taken into consideration as it relates to the appointment of the Trustees -as it relates to race and gender.

   Ms Mbewu in responding to the questions, as it relates to the plans/options in a deficit position, highlighted that there has been a migration from day-to-day benefit plans across the industry, with Members opting to move to

network plans. She further added that the demographic profile for the top plans includes a sicker demographic profile as well as a higher average age. This has resulted in the Members on those benefit options utilising the benefits of their plans more extensively. Year-on-year, the Scheme has seen an improvement in the deficit on the options. It was noted that closing the options in deficit is a challenge because Members would have to downgrade to benefit options that are not aligned with the level of claims that will be received from the Members. The Scheme, as well as the Trustees, are continuously ensuring that there is oversight over the sustainability of the options. Dr Noach added that the Scheme has two subsidies, the first being the health subsidy in place for Members of the Scheme across the benefit options who have been diagnosed with diseases. He highlighted that the highest benefit plans will always run at a deficit because of a concentration of the sickest Members in the Scheme upgrading to those plans to maximise the benefits. The second is the income subsidy for lower-income Members mainly in the KeyCare plan which is subsidised by the higher-income plans. As pricing and benefit adjustments are made to the benefit options, they are sustainable and in accord with actuarial and health economic policy.

In relation to the NHI Bill, Ms Mbewu explained that the Scheme is analysing the impact of the potential introduction of LCBOs to the Scheme's financials. In the event that the LCBO framework is approved, members will be communicated with extensively on the differences in the benefit options. The LCBO framework will be premised on primary and preventative benefits. It is anticipated that the prescribed minimum benefits will not be covered in the LCBO options. It is imperative that Members understand the implications of moving to an LCBO.

In responding to the question on the Board's demographics, the Chairperson highlighted that five of the Trustees are elected by the Members of the Scheme, and two appointments are in progress, with the demographic of the Board having been taken into consideration.

2. Mr Raschid Vania commented that the Chairperson's indication that one of the questions related to the 10.2% administration cost paid as a percentage of contributions, amounting to approximately R8.1 billion, and asked whether this was a fair amount for Members to contribute to DH for their services and whether the surplus funds of the Scheme cannot be utilised to contribute to the administrative expenses. Mr Vania posed a second question relating to whether it was the best option for the administrative services of the Scheme to be outsourced. The third question posed by Mr Vania related to the brokerage fees paid and how Members are not getting the benefit of the broker services despite contributing to the fees paid.

   The Chairperson commented that a special committee was established by the Board, and with the assistance of external specialists, the Board thoroughly assessed the options available to it. The conclusion was that the options, aside from the renewal of the DH contract, were not feasible. Sourcing another administrator would not yield satisfactory results. The Scheme is complex, and it will not be feasible to insource as DH will then become a competitor of the Scheme. Ms Mbewu added that the administration fees of R8.1 billion does not only include administration services but is made up of the actual administration services of R6 billion as well as the accredited managed healthcare services of R2.1 billion. She added that the Board has engaged on the issue and concluded that there are benefits in retaining the services of DH with improved oversight over the Administrator, as well as the services provided on behalf of the Scheme.

   The Chairperson added that the surplus of the funds would be, as an example, allocated to the deferral of the contribution increases for Members and that the statutory minimum solvency of the Scheme, as regulated, is 25%. Dr Noach confirmed the Scheme is solvent and has a surplus. The surplus resulted from non-COVID-19 related healthcare utilisation decreasing by over 10% which was in excess of the COVID-19 related costs. In 2021, there was a six-month delay in contribution increases for Members, with a delay of nine months in 2022, and three months in 2023. The effect of the delays reduced the surplus by effectively R8.6 billion. In addition, the WELLTH Fund was introduced and is estimated to account for R1.5 billion, which will be funded by the surplus. Taking actuarial projections for the Scheme into consideration, considering current medical inflation and utilisation, the surplus will be down to 27% or 28% by the end of 2025. Dr Noach advised that the administrative fees would remain below 10% of the gross contribution income which was agreed upon by the Board. He added that the administration fees are the fifth lowest of the open medical schemes and below the guidance from the CMS. The fees are lower than the global benchmark of about 18% of contributions being paid to administrative fees.

In responding to the question on broker fees, Ms Mbewu commented that the fee is approved by the Minister of Health and the CMS. A Circular is published on an annual basis regarding broker fees. For the 2022 year, the gazetted amount was the lesser of R106.19 or 3% + VAT. She reiterated that the fees are not determined by the Scheme. She added that all Members of the Scheme have the option to utilise the services of a broker registered with and accredited by the CMS. The contribution paid by the Member is not increased with the broker fees, which would be in contravention of the Medical Schemes Act. Dr Noach added that the medical scheme environment is complex and requires access to adequate advice. The financial advisors are trained to assist Members with understanding plans that are in line with their affordability at a point in time. The Scheme continues to grow and has had an influx of new, young Members, which protects the Members of the Scheme at large from excessive contribution increases. The primary driver of the new growth is from the brokers, which is in the best interest of the Scheme.

Mr Vania responded that the Members should have the option to utilise the services of the brokers and should not be subsidised by Members who are not utilising the services of the brokers.

Ms Mbewu reiterated that the Scheme is regulated as it relates to the broker fees. The Chairperson emphasised that the Scheme would continue to engage Mr Vania on the issues raised, along with the CMS if required outside of the meeting.

3. Ms Isabel Mavis Dinalane questioned the availability of benefits in lieu of mammograms and pap smears and mentioned that she was not receiving statements.

   The Chairperson indicated that service consultants were available to assist with the queries, Dr Noach supported the Chairperson and advised that the Scheme Members have full cover for the mammogram benefit once a year, or once every two years based on their risk profile. In addition, the digital channel may be utilised to find the closest mammography centre through the "Find the Provider" tool. In relation to statements, a statement is received after each claim and may be accessed on the Discovery website, through the call centre or the WhatsApp channel through a virtual agent. Ms Mbewu added that if the statements are not being received, it is imperative to confirm that the Scheme has accurate contact information.

The Chairperson observed that there did not appear to be any further questions relating to the financial statements.

4 Governance

4.1 DHMS Trustee Remuneration Policy and Approval of the 2023 Trustee Remuneration

The Chairperson introduced Mr Bongani Hlophe, the Chairperson of the Scheme's Remuneration Committee and advised that Mr Hlophe will present the DHMS Trustee Remuneration Policy and the proposed 2023 Trustee remuneration to the meeting.

Mr Hlophe commented that the presentation will cover the following items:

1. Remuneration Governance
2. Trustee Remuneration Policy
   - Remuneration Methodology
   - Remuneration of the Board of Trustees
3. Proposed 2023 Trustee Remuneration

Remuneration Governance

Mr Hlophe explained that the Board was responsible for the development and implementation of a remuneration policy for Scheme employees, as well as Trustees and Board Committee Members. The Board has delegated the responsibility of oversight of the implementation and the policy to the Remuneration Committee ("RemCo"). The remuneration policy is highlighted in the Integrated Annual Report. Mr Hlophe highlighted that there were no changes to the policy from the previous year.

In 2022, RemCo comprised four Trustees and two Independent Committee Members. In accordance with DHMS policy, one member of the Committee must be the Chairperson of the Board and there should be, at minimum, two Independent Committee Members. Currently, the Chairperson of RemCo is an Independent Committee Member.

The adoption and approval of remuneration were recommended by RemCo before being provisionally approved by the Board and subsequently presented to the AGM for the Members to provide a vote.

The Remuneration Policy for Trustee and Board Committee remuneration for each forthcoming financial year is reviewed and recommended by RemCo to the Board for approval, and thereafter tabled at the AGM for a non-binding advisory vote by Members.

In terms of disclosure, the remuneration practices are in line with Circular 41 of 2014 as issued by the CMS. Trustee remuneration is disclosed through various channels:

- At the AGM to the Members of the Scheme.
- In writing by submission to the CMS (the Regulator for all medical schemes).
- In the Annual Financial Statements, within the Integrated Report which is published annually.

Remuneration Methodology

In terms of methodology, the objective of the remuneration policy for the Board and Board Committees is to provide a legal and policy framework according to which all remuneration decisions were made, validated, implemented, approved, and reported by the Scheme.

In 2014, the CMS published Circular 41 in respect of Trustee remuneration. RemCo engaged PricewaterhouseCoopers ("PwC") to assist in developing a new remuneration methodology and system of benchmarking which has been approved by the CMS and has been in operation since then. This is submitted to the CMS by the Scheme each year for ongoing approval.

The Trustees are entrusted with the role of oversight over an evolving and complex entity, which requires a certain calibre of individuals to address the complex issues at a macro level.

Proposed 2023 Trustee Remuneration

In terms of the methodology, Trustee remuneration is paid at a professional hourly rate. This considers the fact that the Scheme is a not-for-profit entity, with a discounting factor of 30%.

The discounted professional fee proposed for the 2023 financial year was R4 260 (excl. VAT). This was the proposed amount, which represented a 6.7% increase on the approved 2022 rate. The increase proposed was in line with the inflation rate prevailing at the time, whereas the proposed increases in the preceding two years were below the inflation rate.

Remuneration of the Trustees

The methodology utilised for Trustee payment is according to the schedule of meetings the Trustee is required to attend in any given Financial year. The total amount of fees payable to Trustees and Board Committee Members is comprised of two elements:

- 70% is the annual base fee per Trustee/Board Committee Member
- 30% is attributable to meeting attendance.

The annual base fee and fees per meeting payable to Board Committee Members differs from the fees of the Trustees.

Fees are exclusive of VAT and insofar as a Trustee may be registered for VAT, they are obliged to collect VAT and remit to the South African Revenue Services. The Scheme is obliged to pay VAT in the event of a VAT registered provider in any respect.

Trustees are not remunerated for training, do not to participate in or benefit from incentive-programmes, nor are they paid any consulting fees. Trustees are however, reimbursed for reasonable expenses often incurred by way of travel, which are payable to Trustees on approval.

Mr Hlophe noted that the role of the Chairperson of the Board is more involved than the role of the other Trustees. The proposed Trustee remuneration for the Chairperson of the Board, for the 2023 year is a total estimated fee of R834 960. This is based on a proposed total number of 196 hours for the preparation and attendance of an estimated seven meetings per year.

The proposed Trustee remuneration for the 2023 year is a total estimated fee of R477 120. This is based on a proposed total number of 112 hours for the preparation and attendance of an estimated seven meetings per year.

The proposed remuneration for the Chairpersons of the Board sub-committees for the 2023 year is a total estimated fee of R264 120. This is based on a proposed total number of 15.5 hours for the preparation and attendance of an estimated seven meetings per year.

It was highlighted that although the remuneration policy vote is a non-binding advisory vote and thus not legally binding, there is substance and utility that emanates from the vote. The focus in the coming year is to review the remuneration policy.
Mr Hlophe proceeded to propose for the approval of the remuneration policy, as well as the proposed Trustee remuneration for the 2023 year.

Members were offered the opportunity to pose questions relating to the above presentation. In this regard the following can be noted:

Mr Raschid Vania posed a question regarding the 2022 annual remuneration increase of the Principal Officer and how the increase seemed not aligned to inflation.

The Chairperson of the Board responded that the Principal Officer's remuneration was benchmarked against peer remuneration and was noted to be below inflation in the previous years. The increase was to make up for the lag in increases in the previous years.

There being no further questions Mr Hlophe handed over to the Chairperson.

4.2 Appointment of Auditors

The Chairperson advised that the Board had resolved to reappoint PwC for 2023 on recommendation from the Audit Committee. Further, the Board had resolved that Deloitte be appointed from 01 January 2024. He noted that Independent Board for Regulatory Auditors ("IRBA") published a requirement in 2017 that required the compulsory rotation of auditors of public interest entities after serving for ten consecutive financial years. The rule came into effect on 01 April 2023 but has since been put on hold by the Supreme Court of Appeal. PwC was the auditor of the Scheme for twenty-two financial years and the Scheme has implemented the rotation, in line with good corporate governance practices. A recommendation was made to the Board by the Audit Committee to rotate the auditors along with the recommendation that Deloitte succeed PwC, which recommendation the Board accepted. Ms Penny Binnie will be the partner responsible for the audit for the financial year ending December 2024.

The Chairperson proposed that PwC be appointed as the auditors for 2023, and that Deloitte be appointed for the 2024 financial year. This vote was covered under Resolution 2 and voting would take place during the voting process, which had been declared open.

5 Motions

The Chairperson advised that, in terms of Rules 25.1.6 and 25.1.7 of the Scheme Rules, the Principal Officer received no valid motions for the AGM.

There was, however, a motion about the tenure of the Trustees that would be addressed under agenda item 6.

6 General

The Chairperson enquired whether there were any other issues that Members would like to raise under General. In this regard the following can be noted:

1. Mr Aubrey Kuhn raised a question about the increase in contributions for pensioners and pensioners' need to downgrade their plans to remain on the Scheme. He further questioned whether the Scheme would be able to subsidise contributions for long-standing Members of the Scheme.

   Ms Mbewu by acknowledged the challenges faced by many Members of the Scheme and Members of society at large, as demonstrated by Mr Kuhn's question. She added that the challenge is the continued access to benefits in relation to contributions received, as well as maintaining the minimum regulatory solvency of 25%. The affordability constraints of Members have been considered and alongside DH, tariffs and networks are managed in an attempt to curb the utilisation rate. Rigorous analysis, insight and constant engagement has been undertaken to ensure that the contributions remain affordable for Members. Dr Noach added that the issue is genuine. He advised that medical contributions have been consistently increasing around 3-4% above the CPI, which has been an issue. Medical inflation is consistent across the industry and is a global healthcare problem. He highlighted that DHMS has outperformed the market as it related to medical inflation. He added that the Medical Schemes Act requires that all Members on each plan pay the same contribution and the Scheme is therefore not able to discount the contributions of certain Members of the Scheme.

2. Mr Rashid Vania raised a question on the effects of the NHI Bill on the Members and how NHI will function.

   The Chairperson responded that the concept of Universal Health Coverage through the NHI bill is supported by the Scheme as it relates to affording South Africans who are not insured, their right to healthcare. The Scheme is, however, not in support of parts of the NHI Bill, including those relating to medical schemes, particularly their phasing out. The government is unlikely to be in a position to provide universal health cover in the foreseeable future.

   The second point to make was that the Portfolio Committee had not taken into consideration the cost when passing the NHI Bill and the estimates have come to about R350 billion per year. Even if the reserves of all the medical schemes in the country were to be utilised, it would not be sufficient to fund the R350 billion per year. It is expected that the Bill will be presented to Parliament, and there will likely be substantial opposition from the National Council of Provinces. There are likely to be Constitutional challenges which are of concern to the Department of Health.

3. Mr Michael Chukudu raised a question regarding the possibility of the Scheme subsidising co-payments incurred because of hospital admissions, seeing as these are not covered by the Scheme.

   The Chairperson suggested that Mr Chukudu seek assistance from advisors since the matter is one of a personal nature. Dr Noach responded that all the medical plans on the Scheme provide full in-hospital cover, without co-payments. Certain plans have restrictive requirements to obtain full cover. An example of this is the utilisation of the network plans, which require that Members utilise certain network hospitals to receive full cover. The Priority Plan series has stipulated deductibles. The Scheme can charge lower contributions on this series as a result of the deductibles for hospitalisation for particular reasons. Another reason for co-payments would be the health professional fees. The Scheme has contracted with 90% of doctors in the country to protect Members from co-payments. Members can contact the call centre to verify whether their selected doctor a contracted doctor. The co-payments may stem from the 10% of doctors that have chosen not to contract with the Scheme. In emergencies, where Members do not have the time to find the doctors contracted to the Scheme, this would fall within the prescribed minimum benefits which will be covered by the Scheme.

   The Chairperson noted that there no further questions and proposed to move to the voting.

The Chairperson clarified that the Chairperson of the Remuneration Committee is not a Trustee of the Scheme, but rather an independent committee member.

7 Voting and closure of the AGM

The Chairperson indicated that item 7.5 on the agenda proposes that Members vote on the tenure of the elected and appointed Trustees. The current tenure is three years for the first term, which can be renewed for a further three years as a second term, with a cooling-off period of one year after serving two consecutive terms. It is proposed that the tenure for each term be increased to four years, subject to a cooling-off period of two years. The Chairperson specified that current Trustees would not be able to benefit from the increase in tenure. The term of four years would allow for extended knowledge and experience for the Trustees to better discharge their fiduciary duties. The necessary research has been conducted and the proposal is in line with best practice. The proposal will be applied prospectively.

The Chairperson reminded Members that voting on all resolutions would remain open until 16:00 on 08 June 2023, after which voting will close and no further votes will be accepted.

There being no further business, the Chairperson thanked all Members for attending and engaging with the Scheme and declared the AGM closed.

[Note: The use of sign language interpreters was used throughout the proceedings of the AGM]